

## **EXHIBIT 3**



June 29, 1998

Office Note

Patient Name: Johnny Sasser.

Mr. Sasser returns for a follow up visit.

Mr. Sasser is still complaining of significant low back pain and cramping in the calves of both legs. Recently he had a transient episode lasting about 30 seconds of numbness from his waist down but this resolved rather quickly. He continues to have erectile dysfunction. I had a long and detailed discussion with Mr. Sasser.

Assessment: He has chronic bilateral L5, S1 radiculopathies.

Plan of Action: 1. I gave him a prescription for Amitriptyline 25 mg q hs. He may increase by 1 tablet every week to help him sleep at night and to ease his back pains. 2. For his cramps I advised him that he should continue taking Benzodiazepines as he is. However, we will need to consider ~~if~~ another agent. I am hesitant to start him on another drug now because I do not want to give him too many medications. If the Amitriptyline works then we will consider adding an anti-cramp agent. 3. I have obtained a sedimentation rate and a CPK to try and explain his myalgias and to exclude the possibility of an inflammatory process.

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REC'D APR 22 1999

NERVE CONDUCTION STUDY  
EMG REPORT

Patient Name: Johnny Sasser.

Interpretation:

Right median nerve motor study recording from APB and stimulating at the wrist revealed a latency of 4.1 milli second and an amplitude of 7 milli volts. Stimulation at the elbow revealed a latency of 9.1 milli seconds and an amplitude of 6.8 milli volts.

The right median sensory nerve study recording from the index finger and stimulating at the wrist revealed an onset latency of 3.2 milli seconds and an amplitude of 16.8 micro volts.

The right median F wave was 31.67 milli seconds.

Right ulnar nerve motor study recording from the right ADM and stimulating at the wrist revealed a latency of 2.8 milli seconds and an amplitude of 8.4 milli volts. Stimulation below the elbow revealed a latency of 7.3 milli seconds and an amplitude of 8 milli volts. Stimulating above the elbow revealed a latency of 9.5 milli seconds and an amplitude of 7.8 milli volts. The velocity from the wrist to below the elbow was 55.3 m/s. The velocity from above elbow to below the elbow was 64.6 meters per second.

Stimulation of the right peroneal nerve, recording from the EDB and stimulating at the ankle revealed a latency on the left of 4.3 milli seconds and on the right of 4.7 milli seconds with an amplitude on the left of 4.1 milli volt and on the right of 5.2 milli volts. Stimulation below the fibular head revealed on the right a latency of 13.6 milli seconds and on the left a latency of 13.2 milli seconds. The amplitude was 3.4 milli volts on the right and 4.2 milli volts on the left. The velocity of the peroneal nerve between the fibular head and the ankle was 45.4 meters per second. Stimulation at the popliteal fossa revealed a latency of 14.5 milli seconds on the left and 15 milli seconds on the right. The amplitude was 3.3 milli volts on the left and 4 milli volts on the right.

The right sural sensory action potential was 6.7 micro volts on the left and 12.3 micro volts on the right.

Peroneal F wave was 52 milli seconds on the left and 59 milli seconds on the right.

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Stimulation of the tibial nerve on the left and the right revealed normal amplitudes recording from the abductor hallucis on both sides. The F wave on the left was 59 milli seconds and

9. The left tibial nerve H reflex revealed a latency of 30.1 milliseconds. EMG needle study was done with a size 40 monopolar needle. The right tibialis anterior, right medial gastrocnemius, right tibialis posterior and long head of the biceps on the left revealed motor units with increased duration, increased amplitude with polyphasia and normal recruitment. The lower lumbar paraspinals, right vastus lateralis, left vastus lateralis, right pronator teres, right biceps and lower cervical paraspinals were normal.

Results: 1. There is no evidence of a polyneuropathy. 2. There is no evidence of carpal tunnel syndrome. 3. There is evidence of a mild chronic bilateral L5/S1 radiculopathy.

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